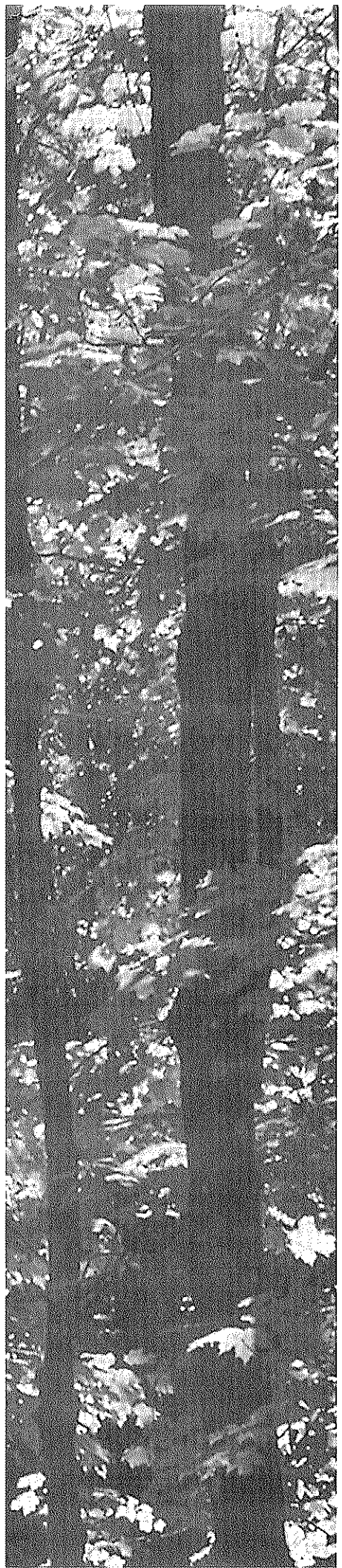

*Findings Brief:*

November 24, 1998

# THE MEDICARE CRITICAL ACCESS HOSPITAL PROGRAM: THE FIRST YEAR

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## ABSTRACT/BACKGROUND

The Medicare Critical Access Hospital Program, part of the Balanced Budget Act of 1997 (BBA), is a nationwide limited service hospital program built on the earlier demonstration programs of Rural Primary Care Hospitals (RPCHs) and Medical Assistance Facilities (MAFs). CAHs can provide outpatient, emergency and limited inpatient services in communities where local use no longer supports a full service hospital. To qualify as CAHs, this new type of hospital must be in a rural area, operate only a small number of inpatient beds, keep inpatients a maximum of 4 days, and be remote from the nearest full service hospital or designated as a necessary provider by the state. CAHs receive reasonable, cost-based reimbursement for their Medicare services.

The Critical Access Hospital Program—a Medicare hospital reimbursement program—is one major component of the BBA's Medicare Rural Hospital Flexibility Program (MRHFP). The other component is a grant program, authorized at $25 million annually for 5 years. These grant funds are for implementation of the CAH Program, improvement of rural emergency medical services, and support of community development activities and other activities to strengthen rural health systems. The first $25 million were appropriated for this grant program in October 1998; these funds are scheduled to be awarded in September, 1999 through the the federal Office of Rural Health Policy, HRSA. This Rural Policy Brief describes the implementation of the Medicare Critical Access Hospital Program in its first year, prior to the availability of any federal grant funds to support the development of the required state rural health plans and technical assistance for hospital conversion.

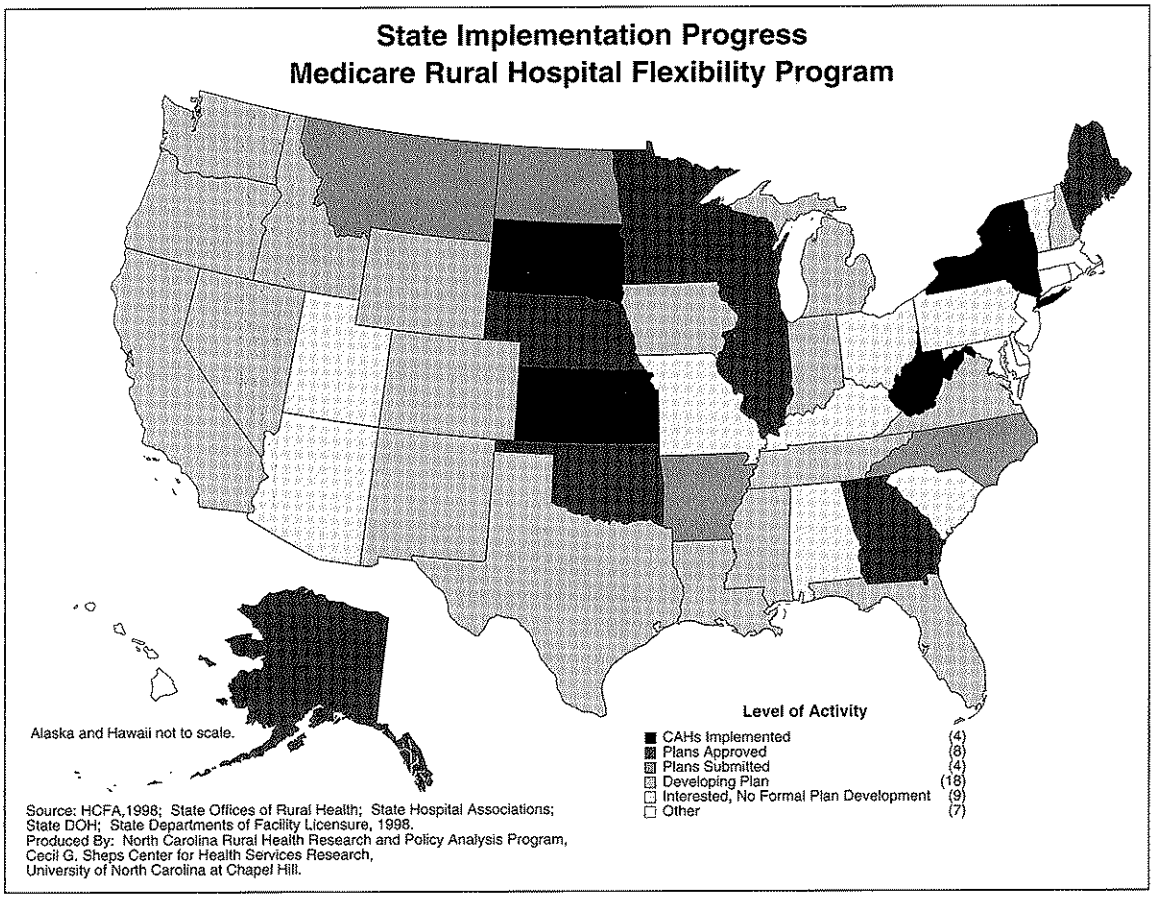
## PURPOSE AND APPROACH

In a study of all fifty states, we examined whether EACH/RPCH and MAF demonstration states have successfully transitioned to the CAH program and additional states have been able to develop the required state plan and begin implementing the program; and identified barriers to program participation encountered by states. Structured interviews with key persons in state offices of rural health, state hospital associations, departments of health, or departments of facility licensing in all fifty states were performed between August 3, 1998 and Sept 10 1998.

## PROGRESS IN PROGRAM DEVELOPMENT

Forty-three states expressed interest in the CAH program. Twelve of these had HCFA-approved state plans as of the date of the interview, four have submitted plans and were waiting for approval, and eighteen were in the process of drafting their state plans. Nine states were attempting to generate interest in the program. Six states did not plan to participate in the program at this time because of a lack of appropriate or interested hospitals.

Thirty-one hospitals in four states were designated CAHs: thirty were formerly RPCHs, and one is a new limited service hospital. Twenty-one MAFs/RPCHs will convert to CAHs when their state plans are approved or at the start of a new fiscal year in their state. State respondents were asked to estimate how many hospitals may convert to CAHs. States that have developed or are developing their state plans estimated that between 158 to 203 would become CAHs. States that are in the early stages of the development process anticipated that from 54 to 90 hospitals may convert to CAHs.




In states where state plans had been approved, respondents expressed satisfaction with HCFA's flexibility in allowing states to determine the criteria for designating hospitals as a "necessary provider." Most state respondents considered this flexibility crucial to the success of the program in their state. Designation criteria for necessary provider vary widely among states. The most commonly cited criteria include mileage between hospitals, demographic indicators, being the sole hospital in a community, location in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA), or designation of the hospital as a Medicare dependent facility.

States that have been successful with plan development appear to be those that participated in the demonstration projects, those in which there was already an ongoing dialogue about the possibility of a limited services hospital program and those with widespread support in the state. States where there was an expressed need for transition to a limited service hospital model from stakeholders, most importantly from hospitals, were also more successful as were states where the office of rural health or lead state agency appeared to have adequate development funds and political power.

## RESPONDENT CONCERNS AND RECOMMENDATIONS

The majority of state respondents expressed concern about the lack of appropriations to support the transition process. Most of these would use funds for technical assistance to provide financial analysis for hospitals that are considering conversion. Other states would use funds for development of the state plan, network development, community assessment and EMS enhancement. Respondents expressed the need for funds to assist in the comprehensive planning that is needed if the program is to assist with the maintenance or improvement of rural health care rather than act as a temporary solution to hospitals in crisis. Other concerns cited by states included adequacy of reimbursement for CAHs, definition of rural which excludes some hospitals that states consider to be rural, potential gaps in services created by loss of full service emergency room, problems with reimbursement from managed care because of the change in status, and the length of stay requirement. State respondents expressed praise for the advocacy efforts of the ORHP and the desire for ORHP to continue an ongoing dialogue with HCFA to address program issues as they arise. They also expressed interest in a mechanism for states to share information and a need for dissemination or creation of materials that could provide guidance for the technical assistance needed to assist potential CAHs with their financial assessments. Respondents in states where initial financial evaluations show poor outcomes of conversion would like to see further exploration of this issue. Respondents also cited the need for contingency planning for other sources of funding or technical assistance if funds are not appropriated, as well as continued strategic planning for how to address the needs of rural hospitals and improve the health of residents in rural communities.

## CONCLUSIONS

In its first year, the CAH program could be implemented in the approximately 15 states where there is sufficient infrastructure at the state level to provide the planning for new conversions and where there is demand from communities or institutions for the program. Other states found it difficult to move ahead effectively to support of conversions without additional resources. The most pressing need for most states, including those implementing and those only planning, is for reliable fiscal consulting or analysis that could be applied to individual hospitals. The program also should be carefully evaluated to determine its effects on the financial status of hospitals, professional recruitment and retention, and quality of care.

To view the full report of this evaluation, visit the NC Rural Health Research and Policy Analysis Program www site: http://www.shepscenter.unc.edu/cah.